[The following items shall be included in the outline of coverage in the order prescribed below.]

Benefit Chart of Medicare Supplement Plans Sold for effective dates on or After June 1, 2010

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available in Kentucky.

[Plans E, H, I, and J are no longer available for sale. (This sentence shall not appear after June 1, 2011.)]

Basic Benefits:

- **Hospitalization** –Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- **Medical Expenses** –Part B coinsurance (generally 20% of Medicare-approved expenses) or co-payments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or co-payments.
- **Blood** –First three (3) pints of blood each year.
- **Hospice** Part A coinsurance

Benefit Chart of Medicare Supplement Plans Sold on or After June 1, 2010

A	В	С	D	F	F*	G	I	K	L	M	N
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, includi 100% I coinsu	Part B	Basic, including 100% Part B coinsurance		Hospitalizati on and preventive care paid at 100%; other basic benefits paid at 50%	Hospitaliz ation and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to \$20 copayment for office visit, and up to \$50 copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursin Facilit Coinsu	ng y	Skilled Nursing Facility Coinsurance		50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsuran ce	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deduc		Part A Deductible		50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deduct							
				Part B Excess (100%)	3	Part B Excess (100%)					
		Foreign Travel Emergency	Foreign Travel Emergency	Foreig Travel Emerg		Foreign Travel Emergency				Foreign Travel Emergency	Foreign Travel Emergency

Benefit Chart of Medicare Supplement Plans Sold on or After June 1, 2010 (continued)

*Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [\$2000] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed [\$2000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

K	L	
Out-of- pocket limit \$[4620]; paid at 100% after limit reached	Out-of- pocket limit \$[2310]; paid at 100% after limit	
	reached	

PREMIUM INFORMATION

We [insert insurer's name] can only raise your premium if we raise the premium for all policies like yours in this Kentucky. [If the premium is based on the increasing age of the insured, include information specifying when premiums will change.]

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

[This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010, have different benefits and premiums. Plans E, H, I, and J are no longer available for sale. (This paragraph shall not appear after June 1, 2011.)]

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to [insert insurer's address]. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

This policy may not fully cover all of your medical costs.

[(for agents:) Neither (insert company's name) nor its agents are connected with Medicare.]

[(for direct response:)(insert company's name) is not connected with Medicare.]

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

[When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. (If the policy or certificate is guaranteed issue, this paragraph need not appear.)]

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

[Instruction to Insurer: Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this document. An insurer may use additional benefit plan designations on these charts pursuant to Section 9.1(4) of 806 KAR 17:570.]

[Instruction to Insurer: Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the commissioner.]

PLAN A

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE	PLAN PAYS	YOU PAY
	PAYS		
HOSPITALIZATION*			
Semiprivate room and board, general			
nursing and miscellaneous services and			
supplies First 60 days	All but @[10@0]	\$0	Ф[1069]/Domt A
First 60 days	All but \$[1068]	Φ0	\$[1068](Part A deductible)
61st thru 90th day	All but \$[267] a	\$[267] a day	\$0
	day		
91st day and after:			
—While using 60 lifetime reserve	All but \$[534] a	\$[534] a day	\$0
days	day		ļ
—Once lifetime reserve days are			
used:			
—Additional 365 days	\$0	100% of	\$0**
		Medicare eligible	
D 11 11 10 100 1	40	expenses	
—Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY			
CARE*			
You must meet Medicare's requirements,			
including having been in a hospital for at			
least 3 days and entered a Medicare- approved facility			
Within 30 days after leaving the hospital			
v s 1			
First 20 days	All approved	\$0	\$0
	amounts		
21st thru 100th day	All but \$[133.50] a	\$0	Up to
21 ma 100m aay	day	Ψ3	\$[133.50] a
			day
$101^{ m st}$ day and after	\$0	\$0	All costs

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet Medicare's requirements,	All but very	Medicare	\$0
including a doctor's certification of	limited co-	co-payment/	
terminal illness.	payment/	coinsurance	
	coinsurance for		
	out-patient drugs		
	and inpatient		
	respite care		

*** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed \$[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE	PLAN PAYS	YOU PAY
	PAYS		
MEDICAL EXPENSES—			
IN OR OUT OF THE			
HOSPITAL AND			
OUTPATIENT HOSPITAL			
TREATMENT, such as			
Physician's services, inpatient			
and outpatient medical and			
surgical services and supplies,			
physical and speech therapy,			
diagnostic tests, durable			
medical equipment,			
First \$[135] of Medicare	\$0	\$0	\$[135] (Part B
Approved Amounts*			deductible)
Remainder of Medicare	Generally 80%	Generally 20%	\$0
Approved Amounts		·	
Part B Excess Charges			
(Above Medicare Approved	\$0	\$0	All costs
Amounts)			
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$[135] of Medicare	\$0	\$0	\$[135] (Part B
Approved Amounts*			deductible)
			·
Remainder of Medicare	80%	20%	\$0
Approved Amounts			
CLINICAL LABORATORY			
SERVICES—TESTS FOR	100%	\$0	\$0
DIAGNOSTIC SERVICES			

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment			
First \$[135] of Medicare Approved Amounts*	\$0	\$0	\$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

PLAN B MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE	PLAN PAYS	YOU PAY
	PAYS		
HOSPITALIZATION*			
Semiprivate room and board,			
general nursing and miscellaneous			
services and supplies			
First 60 days	All but \$[1068]	\$[1068](Part A	\$0
		deductible)	
61st thru 90th day	All but \$[267] a day	\$[267] a day	\$0
91st day and after:			
—While using 60 lifetime	All but \$[534] a day	\$[534] a day	\$0
reserve days			
—Once lifetime reserve days			
are used:			
—Additional 365 days	\$0	100% of Medicare	\$0**
Powerd the additional 265	\$0	eligible expenses \$0	All costs
—Beyond the additional 365 days	φυ	ΦΟ	An costs
SKILLED NURSING FACILITY			
CARE*			
You must meet Medicare's			
requirements, including having			
been in a hospital for at least 3			
days and entered a Medicare-			
approved facility within 30 days			
after leaving the hospital			
First 20 days	All approved	\$0	\$0
	amounts		
21^{st} thru 100^{th} day	All but \$[133.50] a	\$0	Up to \$[133.50] a
	day	40	day
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/ coinsurance for outpatient drugs and inpatient respite care	Medicare co- payment/ coinsurance	\$0

*** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN B

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed \$[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—			
IN OR OUT OF THE			
HOSPITAL AND			
OUTPATIENT HOSPITAL			
TREATMENT, such as			
physician's services,			
inpatient and outpatient			
medical and surgical			
services and supplies,			
physical and speech therapy,			
diagnostic tests, durable			
medical equipment,			
First \$[135] of Medicare	\$0	\$0	\$[135] (Part B
Approved Amounts*			deductible)
Remainder of Medicare	Generally 80%	Generally 20%	\$0
Approved Amounts	Generally 80%	Generally 20%	ΦΟ
Part B Excess Charges			
(Above Medicare	\$0	\$0	All costs
Approved Amounts)	Φ0	Φ0	All costs
BLOOD			
First 3 pints	\$0	All costs	\$0
First 5 pints	ΦΟ	All costs	ΦΟ
Next \$[135] of Medicare	\$0	\$0	\$[135] (Part B
Approved Amounts*	ΨΟ	ΨΟ	deductible)
ripproved rimounts			deductible)
Remainder of Medicare	80%	20%	\$0
Approved Amounts			T *
CLINICAL LABORATORY			
SERVICES—TESTS FOR	100%	\$0	\$0
DIAGNOSTIC SERVICES	100/0	*	* ·

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled care services and	100%	\$0	\$0
medical supplies —Durable medical equipment First \$[135] of Medicare Approved Amounts*	\$0	\$0	\$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

PLAN C MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
	PAIS		
HOSPITALIZATION*			
Semiprivate room and board,			
general nursing and miscellaneous			
services and supplies First 60 days	 All but \$[1068]	\$[1068](Part A	\$0
rist 60 days	All but stillool	deductible)	ΦΟ
61st thru 90th day	All but \$[267] a day	\$[267] a day	\$0
91st day and after:			
—While using 60 lifetime	All but \$[534] a day	\$[534] a day	\$0
reserve days			
—Once lifetime reserve days are used:			
—Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
—Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY			
CARE*			
You must meet Medicare's			
requirements, including having been in a hospital for at least 3 days and			
entered a Medicare-approved facility			
within 30 days after leaving the			
hospital			
First 20 days	All approved	\$0	\$0
	amounts		
21st thru 100th day	All but \$[133.50] a	Up to \$[133.50] a day	\$0
	day		
101st day and after	\$0	\$0	All costs

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ coinsurance	\$0

*** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN C

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed \$[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—			
IN OR OUT OF THE			
HOSPITAL AND			
OUTPATIENT HOSPITAL			
TREATMENT, such as			
physician's services,			
inpatient and outpatient medical and surgical			
services and supplies,			
physical and speech therapy,			
diagnostic tests, durable			
medical equipment,			
First \$[135] of Medicare	\$0	\$[135] (Part B	\$0
Approved Amounts*		deductible)	
Remainder of Medicare	Generally 80%	Generally 20%	\$0
Approved Amounts			
Part B Excess Charges			
(Above Medicare	\$0	\$0	All costs
Approved Amounts)			
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$[135] of Medicare	\$0	\$[135] (Part B	\$0
Approved Amounts*		deductible)	
Remainder of Medicare	80%	20%	\$0
Approved Amounts			
CLINICAL LABORATORY			
SERVICES—TESTS FOR	100%	\$0	\$0
DIAGNOSTIC SERVICES			

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment First \$[135] of Medicare Approved Amounts*	\$0	\$[135] (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—			
NOT COVERED BY			
MEDICARE			
Medically necessary			
emergency care services			
beginning during the first 60			
days of each trip outside the			
USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime	20% and amounts over
		maxi-mum benefit of	the \$50,000 lifetime
		\$50,000	maximum

PLAN D

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[1068]	\$[1068] (Part A deductible)	\$0
61st thru 90th day	All but \$[267] a day	\$[267] a day	\$0
91st day and after: —While using 60 lifetime reserve days	All but \$[534] a day	\$[534] a day \$0	\$0
—Once lifetime reserve days are used:	\$0	100% of Medicare eligible expenses	\$0**
—Additional 365 days —Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
$21^{ m st}$ thru $100{ m th}$ day	All but \$[133.50] a day	Up to \$[133.50] a day	\$0
101st day and after	\$0	\$0	All costs

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co- payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare co- payment/ coinsurance	\$0

*** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN D

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed \$[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE	PLAN PAYS	YOU PAY
	PAYS		
MEDICAL EXPENSES—			
IN OR OUT OF THE HOSPITAL AND			
OUTPATIENT HOSPITAL			
TREATMENT, such as physician's			
services, inpatient and outpatient			
medical and surgical services and			
supplies, physical and speech therapy,			
diagnostic tests, durable medical			
equipment,			
First \$[135] of Medicare	\$0	\$0	\$[135] (Part B
Approved Amounts*			deductible)
Remainder of Medicare	Generally 80%	Generally 20%	\$0
Approved Amounts			·
Part B Excess Charges			
(Above Medicare Approved Amounts)			
, ,	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$[135] of Medicare	\$0	\$0	\$[135] (Part B
Approved Amounts*			deductible)
Remainder of Medicare	80%	20%	\$0
Approved Amounts			
CLINICAL LABORATORY			
SERVICES—TESTS FOR			
DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

PLAN D PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment First \$[135] of Medicare Approved Amounts*	\$0	\$0	\$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT			
COVERED BY MEDICARE			
Medically necessary			
emergency care services			
beginning during the first 60			
days of each trip outside the			
USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges			
	\$0	80% to a lifetime	20% and amounts
		maximum benefit of	over the \$50,000
		\$50,000	lifetime maximum

PLAN F or HIGH DEDUCTIBLE PLAN F MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

A benefit period begins on the first day you receive service as an inpatient in a
hospital and ends after you have been out of the hospital and have not received
skilled care in any other facility for 60 days in a row.

[**This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [\$2000] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [\$2000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[2000] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[2000] DEDUCTIBLE,**] YOU PAY
HOSPITALIZATION*			
Semiprivate room and			
board, general nursing and			
miscellaneous services and			
supplies			
First 60 days	All but \$[1068]	\$[1068] (Part A deductible)	\$0
61st thru 90 th day	All but \$[267] a day	\$[267] a day	\$0
91st day and after:	All but \$[534] a	\$[534] a day	\$0
—While using 60	day		
Lifetime reserve days			
Once lifetime reserve days are used:			
—Additional 365 days	\$0	100% of Medicare	\$0***
Traditional 500 days	ΨΟ	eligible expenses	ΨΟ
Beyond the additional	\$0	\$0	All costs
365 days			

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[2000] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[2000] DEDUCTIBLE,**] YOU PAY
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicareapproved facility within 30 days after leaving the hospital			
First 20 days 21st thru 100th day	All approved amounts All but \$[133.50] a day	\$0 Up to \$[133.50] a day	\$0 \$0
101st day and after	\$0	\$0	All costs
BLOOD First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for out-patient drugs and inpatient respite care	Medicare co- payment/coinsurance	\$0

(continued)

**** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F or HIGH DEDUCTIBLE PLAN F MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed \$[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

[**This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [\$2000] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [\$2000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

		[AFTER YOU PAY	[IN ADDITION
		\$[2000]	TO \$[2000]
SERVICES	MEDICARE	DEDUCTIBLE,**]	DEDUCTIBLE,**]
	PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES			
-			
IN OR OUT OF THE			
HOSPITAL AND			
OUTPATIENT			
HOSPITAL			
TREATMENT,			
Such as physician's			
Services, inpatient and			
Outpatient medical and			
Surgical services and			
Supplies, physical and			
Speech therapy,			
Diagnostic tests,			
Durable medical			
Equipment,			
First \$[135] of Medicare	\$0	\$[135] (Part B	\$0
Approved amounts*		deductible)	
Remainder of Medicare			
	Conorally 8004	Conorally 2004	e0
Approved amounts	Generally 80%	Generally 20%	\$0

		[AFTER YOU PAY \$[2000]	[IN ADDITION TO \$[2000]
SERVICES	MEDICARE	DEDUCTIBLE,**]	DEDUCTIBLE,**]
	PAYS	PLAN PAYS	YOU PAY
Part B excess charges			
(Above Medicare	\$0	100%	\$0
Approved Amounts)			
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$[135] of Medicare Approved amounts*	\$0	\$[135] (Part B deductible)	\$0
Remainder of Medicare			
Approved amounts	80%	20%	\$0
CLINICAL			
LABORATORY			
SERVICES—TESTS	100%	\$0	\$0
FOR DIAGNOSTIC			
SERVICES			

PLAN F or HIGH DEDUCTIBLE PLAN F PARTS A & B

		AFTER YOU	IN ADDITION TO
		PAY	\$[2000]
		\$[2000]	DEDUCTIBLE,**
SERVICES	MEDICAR	DEDUCTIBLE,**	YOU PAY
	E PAYS	PLAN PAYS	
HOME HEALTH CARE			
MEDICARE APPROVED			
SERVICES			
—Medically necessary skilled	100%	\$0	\$0
care services and medical			
supplies			
—Durable medical equipment			
	\$0	\$[135] (Part B	\$0
First \$[135] of Medicare		deductible)	
Approved Amounts*			
	80%	20%	\$0
Remainder of Medicare —			
Approved Amounts			

OTHER BENEFITS - NOT COVERED BY MEDICARE

OTHER BENEFITS - NOT COVERED BY MEDICARE			
		AFTER YOU	IN ADDITION
		PAY	TO \$[2000]
		\$[2000]	DEDUCTIBLE,
SERVICES	MEDICARE	DEDUCTIBLE,	**
	PAYS	**	YOU PAY
		PLAN PAYS	
FOREIGN TRAVEL -			
NOT COVERED BY			
MEDICARE			
Medically necessary			
Emergency care services			
Beginning during the			
first 60 days of each			
trip outside the USA			
71 . 4070 1 1 1			40.00
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime	20% and amounts
itemaniaer of charges	ΨΟ	maximum benefit	over the \$50,000
		of \$50,000	lifetime maximum
		οι φου,σου	mounic maximum

PLAN G
MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board,			
general nursing and			
miscellaneous services and			
supplies	A11.1 + #[1.0.40]	Φ[1000] /D + A	40
First 60 days	All but \$[1068]	\$[1068] (Part A deductible)	\$0
61st thru 90th day	All but \$[267] a day	\$[267] a day	\$0
91st day and after:			
—While using 60 lifetime	All but \$[534] a day	\$[534] a day	\$0
reserve days			
—Once lifetime reserve days			
are used:			
—Additional 365 days	\$0	100% of Medicare	
		eligible expenses	\$0**
—Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING			
FACILITY CARE*			
You must meet Medicare's			
requirements, including having			
been in a hospital for at least 3			
days and entered a Medicare- approved facility within 30 days			
after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
11100 20 days	1111 approved amounts	Ψ	ΨΟ
21^{st} thru $100\mathrm{th}$ day	All but \$[133.50] a day	Up to \$[133.50] a	\$0
		day	
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/ coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ coinsurance	\$0

*** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed \$[133.50] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL			
EXPENSES—IN OR			
OUT OF THE HOSPITAL			
AND OUTPATIENT			
HOSPITAL TREATMENT, such as			
physician's services,			
inpatient and outpatient			
medical and surgical			
services and supplies,			
physical and speech			
therapy, diagnostic tests,			
durable medical			
equipment,			
First \$[135] of Medicare	\$0	\$0	\$[135] (Part B
Approved Amounts*			deductible)
D 1 CM 1			
Remainder of Medicare	C 11 000/	C 11 000/	Φ0
Approved Amounts Part B Excess	Generally 80%	Generally 20%	\$0
Charges	\$0	100%	\$0
(Above Medicare	φυ	10070	φυ
Approved Amounts)			
BLOOD			
First 3 pints	\$0	All costs	\$0
THOU O PHILLO	Ψ~		Ψ~
Next \$[135] of Medicare	\$0	\$0	\$[135] (Part B
Approved Amounts*			deductible)
			, ,
Remainder of Medicare			
Approved Amounts	80%	20%	\$0
CLINICAL			
LABORATORY			
SERVICES—TESTS FOR	100%	\$0	\$0
DIAGNOSTIC SERVICES			

(continued)

PLAN G PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment First \$[135] of Medicare Approved Amounts*	\$0 80%	\$0 20%	\$[135] (Part B deductible)
Remainder of Medicare Approved Amounts			

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE	PLAN PAYS	YOU PAY
	PAYS		
FOREIGN TRAVEL—			
NOT COVERED BY			
MEDICARE			
Medically necessary			
emergency care services			
beginning during the first 60			
days of each trip outside the			
USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime	20% and amounts
		maxi-mum benefit of	over the \$50,000
		\$50,000	lifetime maximum

PLAN K

* You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$[4620] each calendar year. The amounts that count toward your annual limit are noted with diamonds (•) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare co-payment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$[1068]	\$[534](50% of Part A deductible)	\$[534](50% of Part A deductible)◆
61st thru 90th day	All but \$[267] a day	\$[267] a day	\$0
91st day and after: —While using 60 lifetime reserve days	All but \$[534] a day	\$[534] a day	\$0
—Once lifetime reserve days are used:—Additional 365 days—Beyond the additional	\$0	100% of Medicare eligible expenses	\$0***
365 days	\$0	\$0	All costs

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
SKILLED NURSING			
FACILITY CARE**			
You must meet Medicare's			
requirements, including			
having been in a hospital			
for at least 3 days and			
entered a Medicare-			
approved facility			
Within 30 days after			
leaving the hospital			
First 20 days	All approved amounts.	\$0	\$0
21st thru 100th day	All but \$[133.50] a day	Up to \$[66.75] a day	Up to \$[66.75] a day ◆
		\$0	All costs
101st day and after	\$0	·	
BLOOD			
First 3 pints	\$0	50%	50%♦
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet Medicare's	All but very limited	50% of co-payment/	50% of Medicare co-
requirements, including a	co-payment/	coinsurance	payment/
doctor's certification of	coinsurance for		coinsurance♦
terminal illness.	outpatient drugs and		
	inpatient respite care		

(continued)

*** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN K

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

**** Once you have been billed \$[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE	PLAN PAYS	YOU PAY*
	PAYS		
MEDICAL EXPENSES—			
IN OR OUT OF THE			
HOSPITAL AND			
OUTPATIENT HOSPITAL			
TREATMENT, such as			
Physician's services,			
inpatient and outpatient			
medical and surgical			
services and supplies,			
physical and speech			
therapy, diagnostic tests,			
durable medical equipment,			
First \$[135] of Medicare	\$0	\$0	\$[135] (Part B
Approved Amounts****			deductible)**** ◆
Preventive Benefits for	Generally 75% or	Remainder of	All costs above
Medicare covered services	more of Medicare	Medicare approved	Medicare approved
	approved amounts	amounts	amounts
Remainder of Medicare			
Approved Amounts	Generally 80%	Generally 10%	Generally 10% ♦
Part B Excess Charges			All costs (and they
(Above Medicare	\$0	\$0	do not count toward
Approved Amounts)			annual out-of-pocket
			limit of [\$4620])*
BLOOD			
First 3 pints	\$0	50%	50%◆
Next \$[135] of Medicare	\$0	\$0	\$[135] (Part B
Approved Amounts****			deductible)**** ◆
Remainder of Medicare	Generally 80%	Generally 10%	Generally 10% ◆
Approved Amounts			
CLINICAL LABORATORY			
SERVICES—TESTS FOR			
DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$[4620] per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

PLAN K
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment First \$[135] of Medicare Approved Amounts*****	\$0	\$0	\$[135] (Part B deductible) ♦
Remainder of Medicare Approved Amounts	80%	10%	10%◆

*****Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN L

* You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$[2310] each calendar year. The amounts that count toward your annual limit are noted with diamonds (*) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[1068]	\$[808.50] (75% of Part A deductible)	\$[267] (25% of Part A deductible)◆
61st thru 90th day	All but \$[267] a day	\$[267] a day	\$0
91st day and after: —While using 60 lifetime reserve days	All but \$[534] a day	\$[534] a day	\$0
—Once lifetime reserve days are used:—Additional 365 days—Beyond the additional 365	\$0	100% of Medicare eligible expenses	\$0***
days	\$0	\$0	All costs

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
SKILLED NURSING			
FACILITY CARE**			
You must meet Medicare's			
requirements, including			
having been in a hospital for			
at least 3 days and entered a			
Medicare-approved facility			
Within 30 days after leaving			
the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$[133.50] a	Up to \$[100.13] a day	Up to \$[33.38] a day♦
	day		
		\$0	All costs
101st day and after	\$0		
BLOOD			
First 3 pints	\$0	75%	25%♦
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet Medicare's	All but very limited	75% of co-payment/	25% of co-payment/
requirements, including a	co-payment/	coinsurance	coinsurance ◆
doctor's certification of	coinsurance for		
terminal illness.	outpatient drugs and		
	inpatient respite care		

(continued)

**** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN L

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

**** Once you have been billed \$[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES—			
IN OR OUT OF THE			
HOSPITAL AND			
OUTPATIENT HOSPITAL			
TREATMENT, such as			
Physician's services,			
inpatient and outpatient			
medical and surgical services			
and supplies, physical and			
speech therapy, diagnostic			
tests, durable medical			
equipment,			
First \$[135] of Medicare	\$0	\$0	\$[135] (Part B
Approved Amounts****			deductible)**** ♦
Preventive Benefits for	Generally 75% or	Remainder of	All costs above
Medicare covered services	more of Medicare	Medicare approved	Medicare approved
	approved amounts	amounts	amounts
Remainder of Medicare			
Approved Amounts	Generally 80%	Generally 15%	Generally 5% ♦
Part B Excess Charges			All costs (and they
(Above Medicare Approved	\$0	\$0	do not count toward
Amounts)			annual out-of-
			pocket limit of
			[\$2310])*
BLOOD			
First 3 pints	\$0	75%	25%♦
Next \$[135] of Medicare	\$0	\$0	\$[135] (Part B
Approved Amounts****			deductible) ♦
Remainder of Medicare	Generally 80%	Generally 15%	Generally 5%◆
Approved Amounts			

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
CLINICAL LABORATORY			
SERVICES—TESTS FOR			
DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

^{*} This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$[2310] per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

PLAN L PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment First \$[135] of Medicare Approved Amounts*****	\$0	\$0	\$[135] (Part B deductible) ♦
Remainder of Medicare Approved Amounts	80%	15%	5% ♦

*****Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*. Contact your insurance company to obtain a copy.

PLAN M

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[1068]	\$[534](50% of Part A deductible)	\$[534](50% of Part A deductible)
61st thru 90th day	All but \$[267] a day	\$[267] a day	\$0
91st day and after: —While using 60 lifetime reserve days	All but \$[534] a day	\$[534] a day	\$0
—Once lifetime reserve days are used: —Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
—Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$[133.50] a day	Up to \$[133.50] a day	\$0
101st day and after	\$0	\$0	All costs

BLOOD First 3 pints Additional amounts	\$0 100%	3 pints	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare co- payment/ coinsurance	\$0

*** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN M MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed \$[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$[135] of Medicare Approved Amounts*	\$0	\$0	\$[135] (Part B
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	deductible) \$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints	\$0	All costs	\$0
Next \$[135] of Medicare Approved Amounts*	\$0	\$0	\$[135] (Part B deductible)
Remainder of Medicare Approved Amounts CLINICAL LABORATORY	80%	20%	\$0
SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment First \$[135] of Medicare Approved Amounts*	\$0	\$0	\$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL— NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year Remainder of Charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum

PLAN N

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[1068]	\$[1068](Part A deductible)	\$0
61st thru 90th day	All but \$[267] a day	\$[267] a day	\$0
91st day and after: —While using 60 lifetime reserve days	All but \$[534] a day	\$[534] a day	\$0
—Once lifetime reserve days are used: —Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
—Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$[133.50] a day	Up to \$[133.50] a	\$0
101st day and after	\$0	\$0	All costs

BLOOD First 3 pints Additional amounts	\$0 100%	3 pints	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/ coinsurance for outpatient drugs and inpatient respite care	Medicare co- payment/ coinsurance	\$0

*** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN N MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed \$[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$[135] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Balance, other than up to [\$20] per office visit and up to [\$50] per emergency room visit. The copayment of up to [\$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	\$[135] (Part B deductible) Up to [\$20] per office visit and up to [\$50] per emergency room visit. The co-payment of up to [\$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$[135] of Medicare Approved Amounts*	\$0	\$0	\$[135] (Part B deductible)
Remainder of Medicare	80%	20%	\$0
Approved Amounts			
CLINICAL LABORATORY			
SERVICES—TESTS FOR			
DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment First \$[135] of Medicare Approved Amounts*	\$0	\$0	\$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—			
NOT COVERED BY			
MEDICARE			
Medically necessary			
emergency care services			
beginning during the first 60			
days of each trip outside the			
USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges			
	\$0	80% to a lifetime	20% and amounts over
		maximum benefit of	the \$50,000 lifetime
		\$50,000	maximum